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Primitive Ano-Recta a New Observation

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ABSTRACT

The authors report one case of anorectal malignant melanoma, seen and managed in EFD-HGE Unit, Ibn Sina Hopital. It's a very uncommun affection of bad pronostic. At the present time, the surgical management is the only therapeutical attitude.

Introduction

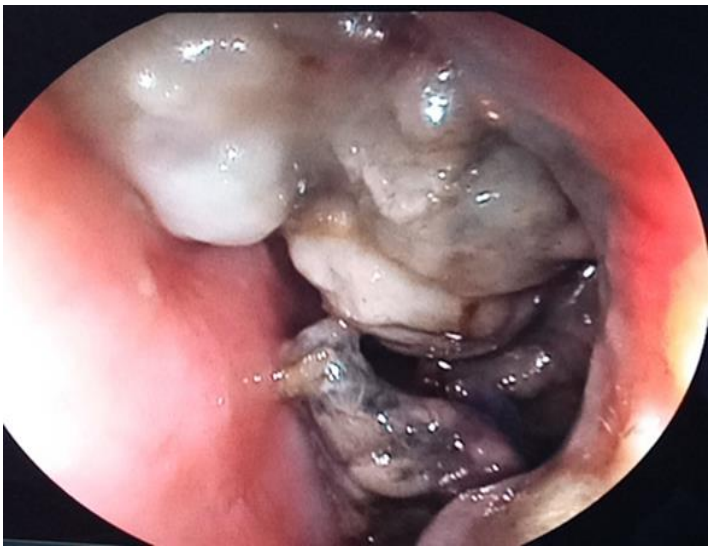
Malignant melanoma (MM) is a rare but extremely aggressive malignant tumor, developed at the expense of the pigment system. It represents between 1-4% of all anorectal tumors. The anorectal localization comes in 3rd place after the cutaneous and ocular localizations, the prognosis remains dark and formidable with a survival rate at 5 years lower than 20% (1-2). An early diagnosis makes it possible to improve the prognosis of these patients. The observation collected at the EFD-HGE unit at the Ibn Sina Hospital through the authors underlines the main characteristics of this condition.

Observation

Observation : Mr. E. HICHAM. 44-year-old consulted in May 2022 for proctalgia evolving for 6 months accompanied by rectal bleeding, mucus emissions and anal pruritus. Examination reveals conjunctival pallor secondary to anemia at 7.9 g/dl and two large bilateral inguinal adenopathies, hard and fixed in relation to the deep plane. The proctologic examination supplemented by a rectosigmoidoscopy reveals a huge ulcerobudding tumor of stony consistency, blackish in color 1 cm from the anal margin. This anal tumor is hemi-circumferential non-stenosing extended over 4cm bleeding spontaneously with stage II turgid internal hemorrhoids. The anatomo-pathological examination with the immunohistochemistry of the endoscopic biopsies concludes to a melanoma.

The thoraco-abdomino-pelvic scanner in favor of a budding tumoral process of the lower and middle rectum with locoregional lymphadenopathy and secondary hepatic, pulmonary and peritoneal involvement

Bone scintigraphy: absence of secondary bone localization. The patient is under palliative radio-chemotherapy.



Discussion

Anorectal melanomas represent between 1-4% of all anorectal tumors and 0.3% of malignant melanomas (1). It has a strong metastatic potential.The disease is more common in older subjects with a peak frequency between the 6th and 7th decade. There is a slight female and Caucasian preponderance (6-8), whereas our patient is male and younger at(44 years old).

On the etiopathogenic level, the hypothesis of chronic irritation remains the most probable, given the exclusion of sun exposure in this location (3).

Clinically, the delay between the revealing signs and the consultation is variable (Table 1).

Author	Number of Cases	Average Consultation times
Moukhliss (9)	14	6 months
Mnif L (4)	2	1 Week
Zakaria G (8)	18	8 months
Our case	1	6 months

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The revealing signs are dominated by proctological manifestations such as rectal bleeding, weight loss and rectal syndrome (table 2).

Table 2. Functional and general signs reported by Zakaria G (2 patients), Moukhliss (14 patients), our series (1 patient)

Clinical signs	Zakaria G(8)	Moukhliss (9)	Our case
Rectorrhagia	18 (100%)	10 (70%)	1 (100%)
rectal syndrome	7 (38, 8%)	6 (42%)	0
Weight loss	9 (50%)	6 (42%)	1 (100%)
pruritus	0	2 (14%)	1 (100%)
diarrhea	0	1 (7%)	1 (100%)

On proctologic examination, anorectal melanoma often presents as an ulcerobudding tumor or a polypoid and pedunculated lesion. The blackish color characteristic of melanoma is present in a third of cases (9). Rectal bleeding was the main symptom in our patient with evidence of a blackish color of the tumor very suggestive of melanoma.

Histological confirmation is based on the demonstration of the melanic pigment within the tumor by conventional FONTANA staining (5,10-11). Recourse to immunohistochemistry may prove necessary in atypical forms using anti-Melan-A and anti-HMB45 antibodies (12). The immunohistochemical study was positive in our patient.

The prognosis for anorectal malignant melanoma is poor. with an average survival of 2 years after treatment. It is a polymetastatic disease by lymphatic dissemination and especially hematogenous as the case of our patient.

Thus, an extension assessment must always be done including a colonoscopy in search of synchronous lesions, a rectal echoendoscopy or a pelvic MRI to assess the parietal thickness and lymph node infiltration and a thoraco-abdominopelvic scanner or a PET-scan. to determine lymph node involvement and distant metastases (14).

The therapeutic means are essentially represented by surgery, varying from a large radical resection of the tumor (abdomino-perineal resection) with inguinal and pelvic lymph node dissection to a conservative gesture by local excision (local excision) the use of one methods is still a subject of controversy. (6,13,15).

Local excision has the advantage of being less aggressive, it is the excision of the tumor mass or scar with a sufficient margin of healthy tissue preserving the entire rectum of the anal canal (14-15) . In localized forms, endoscopic treatment by submucosal dissection has recently been proposed as a therapeutic alternative to surgery (16-17).

Other therapeutic means such as chemotherapy and radiotherapy used as an adjuvant palliative treatment to surgery do not seem to bring a gain in survival compared to surgery alone (17). Radiotherapy has a major benefit in palliative cases. Its association with local excision allows local lesion control similar to abdomino-perineal amputation (6,12). Studies are currently converging on immunotherapy, which has also not been proven to be effective. For our patient, the extension assessment was positive and management was concerted with radio-chemotherapy.

Conclusion

Anorectal malignant melanomas are rare tumors. Despite their characteristic macroscopic appearance, their diagnosis is generally made late. Their prognosis remains formidable, especially because of their metastatic evolution. Surgery remains the main therapeutic weapon.

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